

Doctors' opinions on euthanasia, end of life care, and doctor-patient communication: telephone survey in France

P Peretti-Watel, M K Bendiane, H Pegliasco, J M Lapiana, R Favre, A Galinier, J P Moatti

During the past decade, the debate about legalising euthanasia has grown in many developed countries, including France. Medical journals have reflected this: surveys have assessed doctors' attitudes toward euthanasia and bioethics articles have discussed the pros and cons. Supporters of legalisation argue that euthanasia is a continuation of palliative care and that doctors must respect patients' autonomy, including a wish to die.¹ The latter argument suggests that cultural differences shape opinions about euthanasia, because the emphasis on autonomy is greater in English speaking countries than in other developed countries.^{2,3}

We assessed French doctors' opinions toward euthanasia and collected data about their attitudes and practices. We compared medical specialties which demand different amounts of palliative care and different amounts of empathy toward and communication with terminally ill patients.

Participants, methods, and results

In 2002, the Regional Center for Disease Control of South-Eastern France and the Health and Medical Research National Institute did a telephone survey of a sample of doctors, stratified by specialty. We selected general practitioners, oncologists, and neurologists randomly from all French doctors, kept on file by the National Health Insurance Fund.

We investigated respondents' involvement in end of life care and palliative care, their attitude toward terminally ill patients, and whether "euthanasia should be legalised, as in the Netherlands." We compared medical specialties with Pearson's χ^2 .

We contacted 1552 doctors, and 917 (59%) agreed to participate. Response rate was greater for oncologists

(217/261; 83%) and neurologists (198/287; 69%) than for general practitioners (502/1004; 50%). Doctors who did not respond were generally too busy; they did not differ in sex, age, or size of town from respondents.

Only a minority of respondents were trained in palliative care, especially neurologists (24/198; 12.1%). Oncologists treated more terminally ill patients during the past year (mean 26.3 patients *v* 9.4 for neurologists and 7.0 for general practitioners; $P < 0.05$), and general practitioners practised less often in palliative care units (table). Oncologists were less likely to feel uncomfortable with terminally ill patients (7.8% *v* 16.7% among general practitioners and 27.8% among neurologists; $P < 0.001$) and more prone to systematically communicate the objectives of treatment (65.9% *v* 57.2% among general practitioners and 47.0% among neurologists; $P < 0.01$) and the diagnosis to competent terminally ill patients. Oncologists were also less in favour of legalising euthanasia (35.5% *v* 44.8% of general practitioners and 46.5% of neurologists; $P < 0.05$).

Comment

Many French doctors want euthanasia to be legalised. This opinion is more common among general practitioners and neurologists than among oncologists, who are more experienced in end of life care, more frequently trained in palliative care, and show greater comfort and better communication with terminally ill patients. Because most proponents of legalisation argue that euthanasia is a continuation of end of life care and that doctors should respect patients' autonomy, including a wish to die, we expected to find the reverse.

Regional Center for Disease Control of South-Eastern France, 13006 Marseille, France
P Peretti-Watel
researcher

Health and Medical Research National Institute, Research Unit 379, Social Sciences Applied to Medical Innovation, Institut Paoli Calmettes, Marseille
M K Bendiane
researcher

Departmental Center of Private Health Professionals, Marseille
H Pegliasco
chairman

La Maison, Gardanne, France

J M Lapiana
director of palliative care centre

Assistance Publique Hôpitaux de Marseille, Service of Medical Oncology, Marseille
R Favre
professor

Assistance Publique-Hôpitaux de Marseille, Department of Penitentiary Care, Marseille, France
A Galinier
consultant

Department of Economics, University of Aix-Marseille II, France

J P Moatti
professor

Correspondence to: P Peretti-Watel peretti@marseille.inserm.fr

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French doctors' involvement in end of life care and palliative care, their attitude to and communication with patients, and their opinion on legalising euthanasia, 2002. Values are numbers (percentages) unless otherwise stated

| | General practitioners (n=502) | Oncologists (n=217) | Neurologists (n=198) | Total (n=917) | P value* |
|--|----------------------------------|------------------------|-------------------------|------------------|----------|
| Women | 153 (30.5) | 94 (43.3) | 69 (34.8) | 316 (34.5) | <0.01 |
| Age (years): | | | | | |
| <40 | 124 (24.8) | 102 (47.0) | 78 (39.3) | 303 (33.0) | <0.001 |
| 41-50 | 239 (47.6) | 70 (32.3) | 82 (41.3) | 393 (42.9) | |
| >50 | 139 (27.6) | 45 (20.7) | 38 (19.4) | 221 (24.1) | |
| Mean | 45.3 | 42.3 | 42.8 | — | — |
| No of terminally ill patients cared for in previous year: | | | | | |
| 0-12 | 421 (83.9) | 104 (47.9) | 157 (79.3) | 682 (74.4) | <0.05 |
| 13-24 | 49 (9.8) | 28 (12.9) | 18 (9.1) | 95 (10.4) | |
| >25 | 32 (6.3) | 81 (37.2) | 23 (11.6) | 140 (15.3) | |
| Mean No of terminally ill patients cared for | 7.0 | 26.3 | 9.4 | — | — |
| Specialised training in palliative care, algology, or geriatrics | 103 (20.5) | 43 (19.8) | 24 (12.1) | 170 (18.5) | <0.01 |
| Practising in a palliative care unit | 34 (6.8) | 64 (29.5) | 47 (23.7) | 145 (15.8) | <0.001 |
| Feel uncomfortable with terminally ill patients | 84 (16.7) | 17 (7.8) | 55 (27.8) | 156 (17.0) | <0.001 |
| Systematically communicate diagnosis† | 44 (8.8) | 38 (17.5) | 13 (6.6) | 95 (10.4) | <0.001 |
| Systematically communicate treatment† | 287 (57.2) | 143 (65.9) | 93 (47.0) | 523 (57.0) | <0.01 |
| Euthanasia should be legalised, as in the Netherlands‡ | 225 (44.8) | 76 (35.5) | 92 (46.5) | 394 (43.0) | <0.05 |

*Pearson's χ^2 testing the independence hypothesis between each row and the medical specialty.

†To competent patients.

‡Agreed or strongly agreed.

Our study has several limitations. Answering questions about a sensitive topic on the telephone can be difficult, a questionnaire with a fixed choice of answers prevented doctors from qualifying or justifying their responses, and we lacked detailed information about doctors who did not respond.

Previous studies found similar patterns, but the French counterparts to Italian general practitioners and US oncologists were more in favour of legalising euthanasia.^{3,4} Our findings contradict the argument that opinions on euthanasia are related to cultural differences in English speaking countries; comparative studies are needed.² In France, the support shown for euthanasia may be due to a lack of professional knowledge on palliative care.⁵ Improving such knowledge would improve end of life care and may also clarify the debate over euthanasia.

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Case fatality rates for meningococcal disease in an English population, 1963-98: database study

Michael J Goldacre, Stephen E Roberts, David Yeates

Unit of Health-Care Epidemiology, Department of Public Health, University of Oxford, Oxford OX3 7LF

Michael J Goldacre
professor of public health

Stephen E Roberts
statistician

David Yeates
computer scientist

Correspondence to: M Goldacre
michael.goldacre@dphec.ox.ac.uk

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Meningococcal septicaemia and meningitis are common causes of death in children and young adults. In fatal cases, the time from onset to death is often short. We analysed case fatality rates for meningococcal disease between 1963 and 1998 to determine whether they have decreased.

Methods and results

We used data on meningococcal disease from the Oxford record linkage study database, which includes anonymised statistical abstracts of records of admission to hospital and death certificates in a defined population of 0.35 million people from 1963, 0.9 million from 1966, 1.9 million from 1974, and 2.5 million from 1987 to 1998. We calculated incidence of menin-

gococcal disease and case fatality rates and assessed the significance of trends over time with logistic regression.

From 1963 to 1998, 1223 people had a record of admission to hospital for meningococcal meningitis or meningococcal septicaemia and 25 for other diagnoses—mainly meningitis or septicaemia without specification of an organism and a death certificate that specified meningococcal disease. The median age of these 1248 was 6 years; 255 (20%) were < 1 year old, 422 (34%) were 1-9 years old, 279 (22%) were 10-19 years old, 290 (23%) were ≥ 20 years old, and the ages of two were unknown; 116 died within 30 days and five more within 365 days of admission.

Analysis of the database showed that a further 25 people had died from meningococcal disease. Fifteen

Cases of meningococcal disease* from the Oxford record linkage study database, number of deaths within 30 days and case fatality rate per 100 000, 1963-98

| Time period | Cases admitted to hospital | | | All cases | | | |
|--------------------|----------------------------|--------------|-----------------------------|-------------|---|---------------|-----------------------------|
| | No of cases | No of deaths | Case fatality rate (95% CI) | No of cases | Incidence per 100 000 population (95% CI) | No of deaths† | Case fatality rate (95% CI) |
| 1963-8 | 41 | 5 | 12.2 (2.2 to 22.2) | 42 | 1.23 (0.86 to 1.60) | 6 | 14.3 (3.7 to 24.9) |
| 1969-73 | 72 | 6 | 8.3 (1.9 to 14.7) | 74 | 1.72 (1.33 to 2.11) | 8 | 10.8 (3.7 to 17.9) |
| 1974-8 | 108 | 12 | 11.1 (5.2 to 17.0) | 111 | 1.24 (1.01 to 1.47) | 15 | 13.5 (7.2 to 19.9) |
| 1979-83 | 113 | 11 | 9.7 (4.3 to 15.2) | 113 | 1.09 (0.89 to 1.29) | 11 | 9.7 (4.3 to 15.2) |
| 1984-8 | 147 | 16 | 10.9 (5.8 to 15.9) | 152 | 1.33 (1.12 to 1.54) | 21 | 13.8 (8.3 to 19.3) |
| 1989-93 | 303 | 25 | 8.3 (5.2 to 11.3) | 308 | 2.40 (2.13 to 2.67) | 30 | 9.7 (6.4 to 13.1) |
| 1994-8 | 464 | 41 | 8.8 (6.3 to 11.4) | 473 | 3.55 (3.23 to 3.87) | 50 | 10.6 (7.8 to 13.3) |
| 1963-98 | 1248 | 116 | 9.3 (7.7 to 10.9) | 1273 | 1.97 (1.86 to 2.07) | 141 | 11.1 (9.4 to 12.8) |
| P value for trend‡ | | | 0.31 | | <0.001 | | 0.28 |

*International Classification of Diseases, 9th revision, code 036 and 10th revision code A39.

†Includes 25 people who died outside hospital or who had no record of hospital admission.

‡P values refer to the change in annual rates 1963-98 from logistic regression modelling. Visual inspection of the annual incidence and further modelling showed little change in incidence during 1963-88 (P=0.10) and a significant increase during 1989-98 (P<0.001).



Tables for specific age groups are on bmj.com